



The Fair Havens



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Looking Forward to a Better Day

Solomon wrote, "There is a time for every event under heaven – a time to give birth, and a time to die" Ecclesiastes 3:1-2 (NASB). In the eyes of the Almighty His children are precious in His sight. He knew the number of our days before one of them had come to be (Psalm 139:16), and He has appointed our time to die (Hebrews 9:27). Yet we see in death, only a sleep. Our Hope is anchored on the one who declared himself to be 'the Resurrection and the Life'. Consequently, when we, or our fellow believers face the end of life, we ought not to do so in a spirit of fear, but of power and of love and of a sound mind (2 Timothy 1:7). We look forward to a better day, when the frailties of our flesh are no more and we share in the Divine nature.

That does not mean though that dying is easy. Those approaching the end of their lives may not fear death, but rather the dying process. There may be anxiety about the prospect of a long illness with invasive medical intervention, of uncontrolled pain or of being kept artificially alive by machines. Some may worry about the emotional toil that this would exact on their caregivers. Others may fear dying alone.

For most of our loved ones, these fears are never realized. Many people die in their sleep without pain and with family and friends nearby. For those who have pain, new options in pain control are available when simpler remedies prove inadequate. Physicians who specialize in treating patients who are in pain report that symptom management therapies can provide substantial relief for the vast majority of patients treated.



This issue of *The Fair Havens* addresses issues associated with hospice palliative care—care for people facing life-threatening illness. Hospice palliative care can be broadly defined as end-of-life care, whether it is offered in the community, in hospitals, in one's own home or in a nursing home. Hospice palliative care is a special kind of health care for individuals and families who are living with a life-threatening illness that is usually at an advanced stage. The goal is to provide comfort and dignity for the person living with the illness, as well as a caring environment for the family. It can help make the approaching end of life both manageable and meaningful. The patient's pain is controlled and sedation managed so as to enable him to relate to family and friends. Physical comfort, pain relief, and symptom management together with the patient's spiritual, social, psychological and financial needs all become the focus of hospice palliative care, as does ongoing bereavement counseling for the family. May it be our prayer that the day will soon dawn when our Lord returns to make all things new—when death shall be no more and mourning, crying and pain will have passed away.



End-of-Life Hospice Palliative Care Options

There are a variety of hospice palliative care alternatives available in different settings-- at home, in hospitals, in long-term care facilities and in freestanding hospices. The options may vary depending on where you live. Not everyone in the final stages of life receives hospice palliative care; some die in acute-care hospital wards without the benefit of specialized expertise in pain and symptom management. For this reason, it may be beneficial to investigate the hospice palliative care available in your community that can better equip you to provide good end-of-life care for your loved one.

Several things should be considered when you're deciding whether to choose home-based hospice palliative care. First, evaluate whether it is important to you, your family and your loved one to care for him at home. Then, assess whether the physical layout and facilities of your home are suitable to the type of care you would need to provide. Finally, ascertain whether a palliative care team—a doctor willing to visit the house, nurses and hospice volunteers—is available.

Hospice Care in the Home

Many brothers and sisters may wish to spend their remaining days in familiar, comfortable surroundings but their families may require outside help to provide the necessary care. Being at home may help people remain involved with their families and live as normally as possible. Some people feel that when they are at home they have more freedom to make choices about their care.

Hospice palliative care is generally provided in people's homes through home-care programs, sometimes known as community care access centres. These programs offer professional nursing care and a variety of home support services. In some provinces, home-care programs manage the delivery of home-care services, as well as the coordination of referrals to an alternative care setting when it becomes necessary. Other services may be available in some communities to help people remain at home, including volunteer services, day programs in a variety of places in the community (including hospices) and, in some areas, pain and symptom management teams together with 24-hour response teams that address urgent needs on a short-term basis.

In-Home Nursing and Respite Care

Community-based services and program services in the home can provide occasional respite for the caregiver, wherever the patient is—at home, in the hospital or in a long-term care facility. Many organizations provide in-home nursing. One of the oldest national organizations is the Victorian Order of Nurses of Canada (VON Canada, www.von.ca), which has over 8,000 health-care providers and 15,000 people who deliver home nursing, health



promotion and support to Canadians across the country.

Volunteer Services

Community volunteers can often enhance the quality of care provided by the team. Especially in rural areas, community volunteer services can play an important role and provide emotional support up to and after death. Volunteers are a source of information and practical help for both the patient and his caregivers. National qualifications are currently being standardized, and volunteers can offer support to caregivers in some or all of these areas—bereavement, emotional encouragement, nutrition, physical care, social and spiritual issues, mobility and rest. Some volunteer organizations may be able to provide some or all of the following: equipment, a transportation service to drive people to appointments, meal delivery, respite care and so on. Ask members of your hospice palliative care team what support is available in your community.

Day Programs

Day hospice programs are offered in a variety of places in the community. These programs are best suited for those whose disease is not too far advanced. Day programs are social, caring environments, often run by a hospice palliative care program for all or part of the day. They offer various



kinds of support, including meals, complementary therapies, activities and outings.

Pain and Symptom Management Teams and Emergency Response Teams

In some places, you may be able to obtain services such as pain and symptom management, as well as the services of emergency response teams—including a hospice palliative care nurse or doctor—that respond to urgent needs on a short-term basis. These services are usually coordinated regionally or, if your loved one is at home, through community care access centres.

Residential Hospice Palliative Care

In Canada, three types of settings provide residential, or 24-hour, care: residential hospices, hospice palliative care units in hospitals and long-term care facilities.

Hospitals

Some hospitals have special hospice palliative care units.

Others set aside a certain number of beds in different units in the hospital for people needing palliative care. Hospitals may also have a palliative care team made up of health professionals who are specialists in palliative care. They help the staff provide palliative care on the unit where the dying person is staying.

Long-term or Continuing Care Facilities

Hospice palliative care services may also be offered in long-term care facilities, such as nursing homes or continuing care facilities. Residents who need more specialized palliative care services must sometimes enter a hospital. Currently, long-term care facilities are less likely than hospitals to have specialized hospice palliative care units.

Residential Hospices

Although they are still relatively scarce, “free-standing,” community residential hospices—separate settings where hospice palliative care is provided in a home-like environment—are increasing in number. These hospices are often disease specific, although sometimes they accommodate people with any life-threatening disease. The average stay in a community residential hospice is about two weeks. Some people do not want the memory of a loved one’s death having occurred in their home or, for various reasons, are unable to provide care at home. Patients in residential hospices have the benefit of a home-like atmosphere, and their family members may relinquish their roles as primary caregivers and concentrate on being loved ones. Residential hospices can also be a resource for people who don’t have other support at the end of their lives.

The Health-Care Team

Establishing good channels of communication with the physician and the entire health-care team is essential for the physical and emotional comfort for your loved one. The

team can be quite large and may include a hospice palliative care doctor, hospice case managers or hospice case coordinators, a home-care nurse, occupational therapists, physiotherapists, social workers, respiratory therapists and volunteers, personal care workers or home support aides who provide respite care, a pharmacist, a dietician and complementary therapists. Having a good relationship with the primary or family physician—one of the most important people on the team—is vital.

Communicating with the Health-Care Team

A core principle of hospice palliative care is that the patient is ultimately responsible for decisions about their own care. As a primary caregiver, however, you may find yourself actively involved on the patient’s behalf with other members of the health-care team. You and your loved one must be able to communicate well with the various healthcare providers. Ideally, caregivers and doctors work in partnership. How well team members talk together and understand each other can impact upon your loved one’s happiness and comfort.

You and your loved one will need to talk through, with various team members, the many decisions that need to be made. Making clear or correct decisions concerning end-of-life medical care is difficult. Some people choose to pursue every life-extending treatment possibility, no matter what the side effects or risks. Others value quality of life above all, and this principle governs their care decisions. The option of life-sustaining intervention may be considered a blessing to one patient and a burden to another.

The decisions your elderly loved one may face at the end of life can be complicated and daunting. If your elder is suffering from dementia, you might find yourself making medical decisions for him in the future. Ideally you will have had a chance to discuss end-of-life preferences with your elder and mutually plan the desired course before there is a crisis.

Pain Management and the Health-Care Team

One of the conversations you may need to have with your physician concerns the management of pain. We have come a long way in dealing with the pain that is inevitable in many end-stage diseases. Most painful symptoms can be controlled. People do not become addicted to pain medications that are used correctly, although doses may have to be increased over time if pain worsens and the patient develops a tolerance. If you are the primary caregiver, an informed discussion of pain management issues with your loved one’s physician can be beneficial.

Pain management techniques are constantly evolving. If you feel that your health-care team’s approach to pain management is not working, you may want to suggest



that your doctor consult a pain management specialist or contact an organization such as Pallium (www.pallium.ca), which is dedicated to the education and professional development in palliative care of Canadian health-care professionals and consumers.

Bereavement Support Programs

Bereavement support programs are an integral part of the hospice palliative care philosophy. Bereavement support can start before death, especially in working through the dying process with children. As a person nears death, bereavement support begins in earnest for caregivers. Many people find that it is helpful to have bereavement support for a year after the death of a loved one. Specialized bereavement support groups are available, including grief groups for children, men and bereaved families. Family service agencies, as well as funeral homes, are other sources of support.

Who Pays for Hospice Palliative Care?

Hospice palliative care is paid for in different ways across the country. Who pays often depends on where care is being provided (at home or in the hospital) and on whether it is a core service funded by the local government. It is important to find out as soon as possible who pays for what and what additional financial assistance may be available in your particular case and region.

Community hospice palliative care programs provide services free of charge to clients and their families, and these community organizations are normally supported by a variety of individual and community donations.

Palliative care at home may be paid for by the provincial health plan as part of a home-care program. These plans do not always include the cost of drugs and equipment used at home. Some plans allow only a certain number of paid hours of professional and home support services. Before the allotted hours are used up, you may wish to investigate other funding options.

People may use private insurance or their own money to pay for palliative care services at home. Some may receive assistance from social agencies, service clubs, local cancer societies and other similar organizations.

Hospice palliative care provided in a hospital is usually paid for by provincial health plans. These plans generally cover most care including drugs, medical supplies and equipment while the person is in the hospital. In long-term care facilities, residents are usually required to pay for some of their care. Costs vary, depending on the facility.

Bereavement support is usually free. Often it is provided as part of hospice palliative care services offered in hospitals or by non-profit or volunteer organizations in the community.

Support Networks

Your ecclesia, friends and family are all important com-

ponents of the informal support network that will help you and your loved one. It is best to be proactive in coordinating this help. Think about who is available to help and what they are best suited to do. Be clear with them about how they can best assist. Be specific in your requests. Do you need meals cooked? Do you need someone to take on the job of phoning or e-mailing friends and extended family with news of how your loved one is faring? Do you want people to drop by unannounced, or is it best that they plan their visits?

Don't be afraid to ask for help. Most people want to help, but remember that they may be as inexperienced as you are in a support role and will be most comfortable with clear directions based on what the dying person needs and can accept. Perhaps you might make a list of what you need done and post it so that visitors and family can sign up for a task and you will then know who is doing what and when. Remember it's sometimes hard for people to accept being cared for, especially if they value their independence and autonomy.

The broader community can also play an important role in your circles of support, especially in rural areas. Places of support within the community might include neighbourhood centres, schools, women's groups, family resource centres, public health services, and regional and provincial branches of Family Services. For example, hospice palliative groups increasingly are offering bereavement support in schools.

Family Communications

Family relations can be challenging where the death of a family member is concerned. The more openly you can talk among yourselves, the better. Family discussions are an integral part of care decisions.

Direct clear communication is crucial. Families can be tempted to protect the dying person from the truth. Rather, it is most helpful to give information honestly and to deal with the issues directly as they come up.

A family conference is one good way to bring the family together with the patient to discuss important issues about the care plan, such as where care should be delivered and by whom, the time or desirability for do not resuscitate orders or any other issues of common concern.

Emotions can run very high in families at the best of times, but especially at the end of the life of a loved one. It might be useful to begin family meetings with prayer and a Scripture reading. Sometimes it is best to appoint one family member to represent the family in discussions with the health-care team so that information-sharing and decision-making are as efficient as possible. Other family members can be assigned other important tasks, such as researching services.



Talking about Dying

You may find that friends and family are uncomfortable talking about dying. Death is the subject that everyone knows is there, but wishes to avoid. The mechanisms of denial can be very powerful, and often we lack the language or the comfort to talk about dying. You might spend all your energy taking care of your elder and avoid talking about death, avoiding words like 'terminal' or dying. Your loved one might also avoid the subject.

But the reality is that it is important to broach the subject of death, including your loved one's preferences for end of life care. It may help to ask questions like these: Do you feel this is the last stage of your life? What does quality of life mean at this stage? Now that you are at this stage of life,

what things do you need to do? A useful exercise is to ask family members to think about the aspects of their relationship with the dying person that they might need to finish, and try to help them find the words to do so. It may be the only chance to talk about your fears, seek forgiveness, express your love and appreciation and recall special shared memories. Remember too that your loved one may still have much to contribute to the family. Afford the patient opportunity to finish the things he or she may need to do or say.

The words of Scripture can often take on special meaning to one who is dying. Even if your elder is too sick or mentally impaired to respond, you can still talk, touch, and show affection, reassuring your loved one of your continuing love and care.





Making Ethical Treatment Decisions

Medical technology can be a marvelous tool that God may employ to bring healing, but it is not a cure-all. When therapy is invasive but ineffective, causes extended suffering or creates an excessive burden in terms of physical function and pain, it may be time to stop or withhold treatment. There is no requirement to continue treatment that has no benefit or which may cause a burden to a terminally ill patient. The following guidelines should be considered when making treatment decisions.

- Any medical treatment, intervention or procedure that is expected to improve a patient's condition, prognosis or comfort should be given serious consideration.
- The existence of such treatments or procedures does not require you to utilize them if there is no expected benefit. Each medical situation has its own unique circumstances. The patient's prognosis for improvement should be considered along with the potential of suffering with or without the medical intervention.

- If a patient's condition is irreversibly terminal, the patient or family need not feel morally obligated to use all medical technologies. No longer concerned with 'acute care' where the goal is to cure the patient, treatment shifts to palliative care where the goal is to make the patient comfortable and meet his physical, spiritual and psychological needs.
- Some treatments may qualify as both acute care and palliative care. An intervention that may be curative for one patient may be palliative for another. The question should be, "Does it benefit the patient?"
- Competent adults have the right to refuse or have withdrawn any unwanted medical treatment. If an adult patient is not mentally competent, a proxy decision maker—usually a close family member—is generally recognized to make decisions for the patient.





Tips for Caregivers

These suggestions may help you achieve open and honest communication between you, your loved one and his physician.

- You are your loved one's primary advocate on the health-care team.
- If you have decided to provide care in the home, find a doctor who is willing to visit you there.
- Schedule a triple appointment instead of a single one: the average doctor's appointment is seven minutes, which may not be enough time to ask and get answers to all your questions.
- When making a doctor's appointment, explain why you need to see the doctor and what you hope to get from the appointment.
- Make a list of questions you want to ask and identify their priority. Give a copy of this list to the doctor.
- Your list might include questions such as these: What can we expect from this treatment or procedure? What is its goal? For instance, if palliative chemotherapy is offered, is the goal comfort or a decrease in pain? What kind of crises can we expect, and what might go wrong?
- Many of your questions will stem from fear of the unknown, and many will have no answers. No one can predict how long someone will live; it is more realistic to talk about probabilities rather than ask for precise answers.

- Arrange for friends or volunteers to attend a doctor's appointment with the patient if you or other family members can't. Ask them to prepare questions.
- As primary caregiver, you should act as a second pair of ears during appointments. Take notes so that you can refer to them later.
- Keep a logbook or journal of all care and treatment. Include in it details of the administration of drugs, appointments, names and numbers of the health-care team and so on.
- Remember that, as caregiver, you may notice changes and symptoms that other members of the health-care team do not. Communicate these to other members of the team.
- After appointments, ask for a report or a diagnostic summary if you feel it would be helpful.
- Talk to your doctor before you pursue alternative or complementary therapies, which may interact with prescriptions. Although some alternative therapies may be a way of providing hope and a sense of regained control, scrutinize them as carefully as you would any treatment. Ask how they will improve quality of life, whether they will interfere with other treatment and what benefit can be expected from them. Seek out authoritative research to substantiate claims made about these treatments.

Hospice ... End of Life Care ... A Place of Caring, Comfort and Compassion

Nothing can prepare us for losing a loved one and one of the most difficult things we will ever experience in our lives is to watch a beloved parent, spouse or child die. My 40-year profession in the cancer field did not make it easier to watch my father die. My father, Brother Jim Taggart was a lifelong active Christadelphian and was the anchor of our family. He served his ecclesia and the Christadelphian community faithfully for over 60 years as an ecclesial trustee, arranging board member, Sunday School teacher, presider, exhorter, Bible Class member, Bible School teacher and gathering presenter. He was one of the last brothers who worked in a Conscientious Objector Camp. Throughout his life he was blessed with good health until the age of 89 when he developed metastatic cancer of the parotid gland, which he endured for 9 months before passing away. During his final 9 months he slowly declined and suffered agonizing pain. Throughout his sufferings, he did not complain and never lost his faith or his abiding love for the coming kingdom. To watch a man who was always full of energy, strong, controlled, animated and positive become virtually incapacitated was heartbreaking. In the last 2 weeks of his life our family enjoyed the services of a Hospice.

Unless you have experienced it, you cannot fully understand what a Hospice will do for you. Having a trained medical staff on call 24-7, contacting a doctor, ordering, delivering and administering medications is only a small part of what they do. Hospice staff not only serve and care for the patient, but staff and volunteers are always there for the family as well. Staff answered all our questions with total honesty and prepared us the best they could. We experienced guidance and support from a group of people who truly care and helped us get through one of the most difficult times in our lives.

Our family cannot thank the Hospice enough for taking the burden off of us so we could enjoy the last few weeks laughing and crying with dad, reading and discussing the Bible, reminiscing, visiting with family and friends, and helping us say our goodbyes.

The Hospice staff is caring, concerned and compassionate. They treat each patient as a human being no matter how illness has changed them from the person they used to be. They provided excellent care and spoke gentle, kind words to dad and they provided us comfort, respect and dignity at one of the hardest times in our lives.

History of Hospice Care

Hospice is a type of care that focuses on terminally ill patients' symptoms. These symptoms can be physical, emo-

tional, or psychosocial in nature. Hospice care focuses on bringing comfort, self-respect, and tranquility to people in the final stage of life. Patients' symptoms and pain are controlled, goals of care are discussed and emotional needs are supported. Hospice believes that the end of life is not a medical experience; it is a human experience that benefits from expert medical and holistic support.

The concept of Hospices began in the 11th century. Then, and for centuries thereafter, Hospices were places of *hospitality* for the sick, wounded, or dying and for travelers and pilgrims. The modern concept of Hospice includes palliative care for the incurably ill. The term *palliative* care is an area of healthcare that focuses on relieving and preventing the suffering of patients. Palliative care focuses on the quality of life of terminal patients and does not have a curative intent. Originally the concept of palliative care was viewed with skepticism in the medical community as treatments for the alleviation of symptoms were viewed as hazardous and seen as inviting addiction and other unwanted side effects.

Many of the foundational principles by which modern Hospice services operate were pioneered in the 1950s in the United Kingdom by Cicely Saunders, a nurse, social worker, and writer. Saunders' emphasis focused on the patient rather than the disease and introduced the concept of 'total pain' which included psychological and spiritual as well as the physical aspects. She experimented with a wide range of opioids for controlling physical pain and included the needs of the patient's family in care plans. Saunders' purported that death is a natural process and that death should be eased by sensitive nursing and effective pain-control. "*You matter because you are you, and you matter to the end of your life.*" Cicely Saunders.

At about the same time that Saunders was disseminating her theories and developing Hospices, in 1965, Swiss psychiatrist Elisabeth Kübler-Ross also began to consider the social responses to terminal illness, which she found inadequate. Her 1969 best-selling book, *On Death and Dying*, was influential on how the medical profession responded to the terminally ill and along with Saunders and other pioneers helped to focus attention on supportive care for terminal patients.

The Dr. Bob Kemp Hospice in Hamilton

The Dr. Bob Kemp Hospice is dedicated to excellence in providing dignity, compassion, comfort and support to patients and their families who are facing a life-ending illness. Support is available from the time of diagnosis through bereavement.

The interdisciplinary team of specially trained vol-



unteers and professionals provide social, physical, emotional and spiritual support. Care can be provided in home, in hospital, or in long term care.

In Ontario, Hospices only receive 41% of their funding from the government. This means that Hospices must raise funds to cover operating costs through monetary donations. Patients and families do not have to pay for the Hospice care.

Our Hospice Experience

From the moment dad arrived at the Hospice we experienced a completely different atmosphere from the hospital. There were no restricted visiting hours. The Hospice is beautifully designed with private individual rooms tastefully decorated like a home. Each patient room has a bed, a bathroom, comfortable reclining chairs, phone, TVs, refrigerators and lovely pictures on the walls. Family members were given a homemade quilt tagged ... *made with love by volunteers from our hearts to yours*. The couch pulled out into a bed so that we could stay overnight in dad's room. There was a shower for us as well. The hallway had alcoves with couches, chairs and tables for the family to gather outside the room. Our family started a puzzle on the table outside dad's room and spent many hours together working on that puzzle; unfortunately, we did not finish putting the puzzle together. There was a large kitchen and dining room where we could eat with friends and family. Volunteer staff prepared tea, coffee and meals for us and served us on beautiful china dishes. At the end of the hall a large living room was situated with a fireplace and large windows overlooking a forest. We took dad in a wheelchair to the living room; he always enjoyed viewing God's nature. There was a large dining room area with a piano and we were able to sit dad in a wheelchair and play his favourite hymns, he had tears in his eyes listening to the hymns. When dad could no longer sit in a wheelchair due to his declining health status, we could take the entire hospital bed outside in the garden area as the Hospice was constructed with a huge door so that the bed could go out into the garden.



When dad passed away the Hospice staff made the arrangements with the coroner and the funeral home. And, when dad's body went to the funeral home the entire Hospice staff lined the hallway to say goodbye to him, at the front door a nurse read Psalm 23. His body was wrapped in the homemade quilt made with love. The philosophy of the Hospice was that dad came in through the front door and he was to leave through the front door. After dad's body left we were told we could stay as long as we wanted. Of course, some of us worked on the puzzle and others emptied his room. We were physically and emotionally exhausted and yet it was hard for us to leave the Hospice. We found the Hospice to be much more than a building ... it was an oasis of compassion, kindness and love.

You cannot do a kindness too soon, for you never know how soon it will be too late. Ralph Waldo Emerson.

The last good thing that may happen in a person's life is a Hospice volunteer.

--Sister Marcia Smoke, daughter of Brother Jim Taggart



Foundation's Terms of Reference

How can the Fairhaven Christadelphian Charitable Foundation be of assistance to your ecclesia? Are there health and welfare needs in your meeting that require attention, but ecclesial resources are strained or insufficient? The Foundation, operating under the applicable government regulations, may provide grants only to registered charities in Canada. We must disperse a percentage of our investment income each year, based upon a government regulatory formula.

Ecclesiastical bodies in Canada may request assistance from the Foundation by following these guidelines:

Only requests from Arranging Boards will be considered. Requests from an individual member of an ecclesia will not be accepted by the Foundation. Priority is to be given to the welfare needs of Christadelphian elderly, since this reflects the original purpose of Fairhaven House. If additional funds are available after meeting these needs, then more general health and welfare needs of the Christadelphian community will be considered, followed by health and welfare needs of the community at large. Requests must be in writing and should document, in confidence, the need, the background, the amount of help required and the amount of help being provided by the ecclesia. It is expected that the ecclesia requesting support will also provide funds to assist from its own resources. It is preferable, if possible, that ecclesiastical bodies address emergency situations, and subsequently follow up with a request to the Foundation. The board of the Foundation considers requests at its semi-annual meetings in March and August each year. Emergency requests will also be addressed as quickly as possible.

Requests may be sent to:

The Fairhaven Christadelphian Foundation
c/o Sister Penny Sheppard, Secretary
728 Church Street
Toronto, ON, M4W 2M6

It is important to appreciate that the primary responsibility to meet the welfare needs of our brothers, sisters and young people lies at the ecclesial level, and consequently the Foundation's role is to supplement, rather than supplant this ecclesial responsibility. We encourage ecclesiastical bodies to be actively aware of situations where there is a need, extend help, and then approach the Foundation as a funding partner.

Year End Financial Report

Statement of Revenue, Expenses and Fund Balance for the Year Ending March 31, 2012

Revenue

Investment income	13,041
Donations	5,600
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	18,641

Expenses

Grants	6,050
Professional fees	3,275
Administrative	1,717
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	11,042

Net Income (Loss)	(7,599)
Opening fund balance	358,292
Closing fund balance	365,891

An Appeal

The Foundation would welcome ecclesiastical and individual gifts to support this work of the Lord. Donations may be sent to the treasurer:

Bro. Jonathan Farrar
140 Whitwell Way,
Binbrook, ON, L0R 1C0

The Fairhaven Christadelphian Charitable Foundation
c/o 728 Church Street
Toronto, ON, M4W 2M6
Visit us at www.fairhavenfoundation.ca

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